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ABSTRACT

The lead article by H. Drummond examines the cultural context of psychosis and concludes that madness is deeply rooted in social and sexual inequality. The author, a psychiatrist, supports his argument with case studies, reports on the use of drugs with the psychotic, research on efforts to demonstrate that schizophrenia is a biological illness, and reported changes in the primitive Ik tribe as a result of modernization. The article is followed by brief reactions by a teacher of the emotionally disturbed, a child psychiatrist, two educational consultants for the emotionally disturbed, and a psychologist. Respondents comment on power and poverty, the stigma of labeling, the medical model, the psychotic experience, and effects of environmental stress. (DB)

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IOWA PERSPECTIVE

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News of Programs for Emotionally Disabled and Chronically Disruptive Students
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EDITOR'S COMMENTS, DISCLAIMERS YET NO APOLOGIES

When I first read the articles by Dr. Hugh Drummond excerpted in this issue, I was struck with several salient themes which I believe we must attend to as educators. At the time I was aware that the manner Drummond chose to express himself might offend many educators as well as our colleagues in the field of mental health. Are the points raised and discussed important enough to be reprinted with the danger of possibly offending our colleagues or being misinterpreted? I think so.

Perhaps we need to view being offensive in a relative manner. At times I have the feeling that the only group we don't particularly worry about offending are our clients: whether they are termed students, consumers or patients. And it seems that these persons and their relatives, in a heightened and more than likely transitory state of vulnerability, are going to be the last to yell "foul" when such a response would certainly be appropriate. If this issue is considered offensive, it is my hope that this feeling is more prevalent among our colleagues than our consumers.

By way of disclaimers, it should be clearly stated that the views expressed in the material in this issue do not in any way reflect the position of the Iowa Department of Public Instructon. It is the mission of this organization to work cooperatively with other agencies such as mental health in providing needed services to children, adolescents and young adults in our state. I personally hope that this issue does not in any way impede progress in such a mission. On the other hand, the Department of Public Instruction deserves credit for allowing the exploration and discussion of controversial topics. What better agency to demonstrate freedom of expression, ideas and self-examination?

The lead article by Dr. Drummond is followed by reaction papers from professionals representing education and mental health. These persons were asked to respond to Drummond's article in relation to their agreement or disagreement with his hypotheses and the manner in which these concepts apply to children and adolescents. Another verification for the need to publish this material is exemplified in the thought and courage displayed in these responses. These comments were shared with Dr. Drummond who offers a brief response at the close of this issue.

Is this material meaningful to you as a reader? We need to know.

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Power, Madness and Poverty

by Hugh Drummond, M.D.

This article is an edited version of "Dr. D. is Mad as Hell" and "Power, Madness and Poverty" which appeared in the December, 1979, and January, 1980 issues of Mother Jones Magazine, *and is reprinted with permission of* Mother Jones. *Probably best known for its Ford Pinto expose,* Mother Jones specializes in investigative journalism.

I have spent a good part of my life thinking about madness. I have been a psychiatrist for almost 20 years. My work is in a mental health clinic in a low-income, urban-industrial setting. I teach a little. Most of my clinical contacts are with patients who are considered psychotic. I have all kinds of well-worn, professionalized ideas about madness, but they do not work too well anymore.

Let me begin by describing a scene. It is from *The Titicut Follies*, a film you may have seen. But then again you might not have, because *The Titicut Follies* lacked the pop appeal of *One Flew Over the Cuckoo's Nest* and was banned to the public in Massachusetts. The Massachusetts courts decided that the film's depiction of nudity was an invasion of patient privacy.

Of course, the nakedness in *The Titicut Follies* that was so offensive was not really that of the human body but of our mental health institutions. The documentary shows without comment how the "patients" of the Bridgewater State Hospital are endlessly treated as things.

I single out this one scene from the film because it dramatizes my thesis: that madness is a function of power in our society and that to declare that madness resides solely within the individual is the power elite's lie.

The scene is of a case conference like thousands I have observed and been part of. The psychiatrist sits at the center of a table flanked by a nurse on one side and a social worker on the other. The psychiatrist is, of course, male; the nurse and social worker, female.

A patient is brought before this trinity by two burly attendants. As the patient enters he calls out to the doctor, "Doc, you gotta send me back to Norfolk Prison; this place is making me sicker".

The psychiatrist responds in a tone of voice I know very well, having been masterfully trained in it myself. It has the quality of a steel probe wrapped in velvet. He says, "Why should we want to make you sicker?"

"I don't know and I don't care. All I know is I was better off in prison. Send me back there."

The psychiatrist, having listened attentively, says, "This is a hospital. We're here to get you well, and yet you say we're making you sick."

The patient raises his voice: "Now look Doc, I got nothing against you, but you gotta get me outa here."

The doctor gestures with his hand like the Pope, "Now calm down."

"Don't tell me to calm down. This place is driving me nuts."

Responding to another, subtler gesture from the psychiatrist, one of the attendants steps forward and places a subduing hand on the patient's arm. The patient pulls away, which invites an immediate and irresistible restraint. The attendants drag off the struggling patient, who is now screaming at the top of his lungs. The doctor turns to the nurse and says, as the social worker nods her thoughtful approval, "His id impulses are getting out of control. We'll have to increase the Thorazine."

There is something in this exchange more important than the baiting that went on. The psychiatrist, unlike most judges, was listening to what the patient said. But what the patient had to say was, for the psychiatrist, a commentary not on the hospital but on the patient himself. Even though the patient was uttering the truth, the psychiatrist could only hear the words *as the speech of a patient.*

One of the ways mental hospitals drive people crazy is precisely by treating their language as a restricted code system whose key is hidden from the patient. The powerlessness of patienthood extends to the disenfranchisement of his words. Since the manifest purpose of the mental hospital is to assist the patient in communicating his thoughts more meaningfully, you have a built-in double-bind.

Nowhere is this point on language better made than in a short story by Anton Chekhov titled "Ward No. 6." It describes a psychiatrist who winds up committed to the institution he once directed. The critical point in that fascinating process occurs when a colleague overhears the psychiatrist engaged in a conversation with a patient, during which the patient's words are taken seriously and responded to with something like enthusiasm.

Being a patient means being powerless. A "good" patient accepts his powerlessness. A "sick" patient rebels against it. The fact that follow-up studies of patients who leave mental hospitals "against medical advice" find those people generally doing better than those who await discharge is one of many embarrassing facts.

To understand patienthood, perhaps we should begin with the psychiatric labeling process, which justifies and professionalizes the disempowerment. Volumes of research have been done to demonstrate the absolute unreliability of psychiatric diagnosis. The only consistent pattern is that the more the doctor likes the patient, which by and large means the closer they are in social class, the more likely he is to diagnose the patient as neurotic rather than psychotic. Poor people, blacks and Hispanics are quickly labeled psychotic or character-disordered for the *same behavior* that earns white, middle-class patients the label neurotic (i.e. relatively healthy). To be called neurotic by a psychiatrist is a compliment. They even consider themselves neurotic.

No psychiatrist will call him or herself schizophrenic, however. Nor would he or she take an antipsychotic drug or give one to a respected colleague. While schizophrenia is considered a

"medical diagnosis" like pneumococcal pneumonia or appendicitis, it actually functions as a degradation ritual imposed upon those who have broken some rules of propriety.

Unlike members of primitive societies, who gravely impose sanctions for flagrant social violations, psychiatrists fling around the term schizophrenia with abandon.

In one study, verbatim transcripts of normal speech were given to a group of psychiatrists who were asked to make a diagnosis. The speakers were identified as patients and were unknown to the psychiatrists. They were free of symptoms, led normal lives and had average scores on psychological tests. Forty percent of the psychiatrists chose "acute paranoid schrizophrenia" to describe these examples of normal verbal behavior. One result of the study was particularly upsetting: the more experienced the psychiatrist, the more likely he or she was to choose a more pathological diagnosis.

While the label is affixed with ease, it can never be removed. Innumerable times I have seen a thick medical record in which a medical student had once added schizophrenia to a list of possible diagnoses. Years later an intern who has zipped through the chart will begin a note on the patient by writing, "This is the fifth admission of a 48-year-old male schizophrenic." Everyone concerned is thereby permitted to take the patient's complaints less seriously, which saves a lot of time and trouble. And if mental patients are anything, they are people about whom not much trouble is ever taken.

The people who wind up in mental hospitals tend to be the people who are brought to psychiatric emergency units. The most conspicuous feature of this population, and consequently of the clientele of state mental hospitals, is their poverty. The mental as well as the physical lives of the poor are viewed with less regard than those of the wealthy, which makes it easier to incarcerate the poor with bland indifference.

There are rich people in mental hospitals, however. Every major city has a special resort or two with a country-club atmosphere, where, for a couple of hundred bucks a day plus professional fees, the local elite can comfortably and shamelessly store its eccentric members. But here, too, the major identifying feature of those admitted is their powerlessness. They tend to be either adolescents, whose failures in style are a threat to their mover-and-shaker parents; or the elderly, whose judgments in the use of family trust funds are "irresponsible"; or women, who, well. . ., are just women who are not behaving themselves. An occasional executive vice president may wander through to dry out, but the stocks-in-trade of the affluent asylum are the geriatric-adolescent-female debris of the power elite.

Considering the cock-eyed ease with which mental patienthood is imposed upon powerless people, it is remarkable that so much genius is shown in trying to analyze the biochemical differences between patients and nonpatients. Psychiatrists have indeed outdone themselves to prove that schizophrenia is a disease stemming from an inherent, biochemical defect. That "the disease" is defined by fickle perceptions of conversational style has not prevented a whole juggernaut of chemical crusaders from searching for the defect as if it were the true cross.

You know what happens when crusaders search for the true cross—they find it. So it is not surprising that the psychiatric literature has been silted with a number of breakthroughs in biochemistry in recent years—all dramatic, all unique and all washed away by subsequent waves of researchers sniffing and snorting after a Nobel Prize like pigs after truffles. Taraxein, S-protein, adrenochrome, lactate-pyruvate ratios, dimethoxyphenylethylamine, serotonin, monoamine oxidase, 5-leuc-endorphinemia; they come and go like the tides.

The most popular now is the dopaminergic theory. It is based on the following bit of logic. Tranquilizers control some cases of schizophrenia. Tranquilizers also cause symptoms similar to Parkinson's Disease (the reason for this is that the drugs block the capacity of certain receptors in the brain to respond to a chemical neuro-transmitter called dopamine). Therefore, schizophrenia must have something to do with dopamine production in the brain.

I cannot tell you how many millions of dollars have been poured into that little labyrinth, which, as a theory, makes as much sense as this: Arsenic controls some cases of syphilis. People with arsenic poisoning show traces of it in their hair and fingernails. Syphilis must, therefore, have something to do with people scratching their heads too much.

The pharmaceutical industry has taught psychiatrists to use the word "antipsychotic" rather than "tranquilizer," but the latter term is, in fact, more accurate. Thorazine, Mellaril, Haldol and all their brothers and sisters do nothing more than minimize some of the intense emotion that fuels the delusions and hallucinations of acute psychotic states. Acutely disturbed people treated with such drugs lose the volume of feeling around crazy ideas or perceptions. Without that energy they just stop attending so much to those ideas or preconceptions, which then float back to that sea of preconscious *mishugas* we all carry around.

People on tranquilizers merely care less about their delusions. Unfortunately, they care less about other things, too. Studies by Hogarty, Goldberg and Schooler reported in the *Archives of General Psychiatry* in 1974 show that while there are fewer tranquilizers, there is no improvement in social functioning outside the hospital over that of a control population.

The tranquilizer industry has so dominated the practice of psychiatry that any patient treated with tranquilizers tends to be kept on them indefinitely. There are now about 750,000 Americans walking around like zombies with Parkin's Disease-like symptoms because of these drugs. A little less than half of them can look foward to the general irreversible effects of Tardive Dyskinesia (T.D.) the tongue-biting, lip-chewing behavior that results from long-term major tranquilizer use.

Uncomfortable as it is, T.D. may not be the worst of the tranquilizer time bombs. The one that has everyone a little nervous has to do with another side effect of these magic bullets: increased prolactin secretion. Prolactin is a pituitary hormone that

stimulates the production of breast milk. Prolactin secretion is controlled by dopamine which, you remember, is blocked by "antipsychotics." Some strains of rodents have shown increased growth of either artifically induced or spontaneously occuring breast cancers with added prolactin.

While not all human breast cancers are sensitive to prolactin, the worries persist. Several epidemiological surveys found an increased rate of breast cancer among patients on reserpine. Reserpine was one of the earliest tranquilizers, rarely used now except to control hypertension, but it is a significant prolactin stimulator. Several careful studies have found no increased risk of breast cancer with tranquilizers; but since negative studies are not as convincing as positive ones, the FDA is making threatening noises about the need to warn women about this potential hazard.

Most of the authoritative information about antipsychotics comes from the multihospital Collaborative Study Group of the National Institute for Mental Health (NIMH). Their massive, nationwide, carefully controlled studies (as opposed to the ones supported by the drug industry) demonstrated that the social withdrawal, vocational incompetence and interpersonal defects of chronic schizophrenics were not affected by tranquilizers. The drugs served only to shorten the duration of acute psychoses and reduce the frequency of rehospitalization due to relapses. They did nothing for social alienation or blunted emotions.

The Collaborative Study Group also found that all tranquilizers had very similar effects—despite the sales pitches of the various companies, the differing chemicals involved and the widely divergent prices of the drugs.

Another of the group's studies gave the tranquilizer hucksters a surprising kick in the teeth. One of the problems of long-term drug maintenance is what the industry calls "noncompliance"—patients will claim that they have taken their medication when they have not. The industry insists that this is why patients will sometimes suffer psychotic episodes even when drugs are prescribed. The industry's responses to the problem was to develop new forms of the drugs: tasteless, colorless concentrates, which can be hidden in food; or, more dramatically, "depot" injections in an oil base that permit a single administration of the drug to last as long as five weeks. But the NIMH found that despite the guaranteed administration of drugs, the patients it studied did no better than patients who, however inconstantly, took drugs orally on a supposedly daily basis.

Let me be fair about drug prescribing. When you are confronted with someone who is listening to voices telling him or her to commit murder or with agitated old men or women who are starving to death because of a conviction that their food is poisoned, you prescribe a tranquilizer and hope to hell it works quickly. The only way to maintain ideological purity about drugs or mental hospitals is to avoid contact with people who are psychotic. At times I have even been asked by mental patients' liberation groups to help them medicate and occasionally hospitalize one of their members. Political truths are everywhere, but on the rocky frontiers, dirt gets in the eyes and contradictions stick in the throat. I prescribe tranquilizers and hospitalize people. I tell myself I do it only when absolutely necessary, but often wish I could be forgiven.

There are not too many contradictions about the long-term use of the drugs, however. They just do not work very well for people whose tenuous ties to the rest of us have become a lifstyle. I have discovered many chronic patients who have been kept indefinitely on antipsychotic drugs when, as far as I could tell, they had never been psychotic and should never have been given them in the first place. The greatest problem in such situations is convincing the patient that he or she can do without the "medicine." They have come to believe that they need it as a diabetic needs insulin.

Trying to figure out what schizophrenia is by figuring out how tranquilizers work raises suspicion of a thought disorder itself.

The other "inherent defect" argument for schizophrenia is the genetic one. The assumption that there is a genetic flaw in unwanted and unneeded people is an old and inglorious story. The very desire to search for a genetic basis to behavioral problems has to be seen in the context of politics. When something is seen as "genetic," it becomes fixed in the mind as inevitable, intractable and implacable. Despite all the usual disclaimers about hereditary traits being only tendencies or vulnerabilities to be "acted upon" by environmental influences, the identification of behavior as being genetically transmitted relieves the scientist and the world from having to address the environment.

Earlier in this century, the scientific community insisted that pellagra was a genetic disease found in demented Southern Negroes. A public health pest named Joseph Goldberger was laughed out of universities for insisting that it resulted from a deficiency in impoverished diets (later identified as a lack of niacin). The attitude of respected scientists was consistent with the "red scare" ambiance of the times, when anyone who referred to poverty was considered a bomb-throwing anarchist. Scientific truths have a strange way of reflecting social prejudices.

So do scientific lies. When more than half the scientists who have *ever* lived are alive today and when all of them are lusting for immortality or, at least, their tenures, you can expect fudging of data here and there.

The Arthur Jensen-Richard Herrnstein brotherhood, which espouses the dogma of the genetic endowment of intelligence, has heavily relied on the data of a British scientist knighted for his work. So authoritative and renowned were Sir Cyril Burt's studies that the entire British school system was redesigned with a tracking system (which keeps people in their place) based on his work. As many of you know, it now appears that Sir Cyril lied through his perfect teeth.

Seymour Kety, who has devoted a career to trying to demonstrate that schizophrenia is a biological illness, has spent the last 15 years attempting to prove

that it has a genetic origin. He had his co-workers use the elaborate population registries of Denmark to identify 33 schizophrenics who were adopted at birth. The rates of schizophrenia were then measured in their biological families and their adopted families, and the same was done for a matched group of nonschizophrenic adoptees. The results showed a significantly higher rate in the biological families, including half-siblings related through biological fathers who subsequently remarried. This would seem to demonstrate that even the intrauterine environment is not as important an influence as the purely genetic one.

Well, what can be said? Apparently a lot. The volumes of argument back and forth about the validity of the data and the methods used have proved to be an ecological disaster. I will not even try to summarize them for you.

Even if you grant the study's conclusions, something very interesting emerges. While Kety used the broadest possible definition of schizophrenia (calling it "schizophrenia spectrum disorders"), the data did not hold up for what is called acute schizophrenia but only for chronic and "latent" schizophrenia—whatever *that* means. In other words, the "illness" used to demonstrate the dopamine blockade and other psychopharmacological hypotheses was not the same illness used to demonstrate the genetic ones.

Whatever schizophrenia is, it amounts to the breaking of certain unstated rules of social behavior. Rule-breaking, like rules themselves, exists in a broader context than neuro-physicology. The biochemical approach to mental illness assumes that sharp lines can be drawn through that cloudy residue of rule-breaking, and that the microscopic analysis of those lines will yield the etiology of diseases similar to diabetes or pneumococcal pneumonia. This is reductionistic stupidity similar to trying to understand capital punishment by analyzing the chemical transformations in the muscles of an executioner. Biological psychiatry keeps looking for answers to questions that can only be asked in a laboratory.

There is an old Mutt and Jeff cartoon you may have seen that says it all. Jeff is looking for a lost quarter under a street lamp. A cop comes by and helps him look. After a while the cop says, "I don't see it. Are you sure you dropped it here?" Jeff, not looking up, says, "No. I dropped it down the block, but the light is better here." The cop scratches his head and the final frame shows him resuming the research. You see, it's a compelling argument for scientists as well as cops.

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Imagine a group of people who are always together. Their work totals about 30 hours each week. It is cooperative, proceeds at an easy pace includes everyone and is accompanied by pleasant chatter. There is no distinction between labor, politics, homemaking and play. Children are free to go anywhere because everywhere they are watched, fed and taught as if every adult were their parent. There is much touching. Conflict is discussed until consensus is reached on what is best for everyone. There is no violence. When children fight, they are distracted by amusement or affection from an adult. People take only what they need, and what each needs is what all need. They worship their environment.

Is it a commune or well-analyzed liberals? An est retreat? Paradise?

Now imagine a group of people who have lost their humanity. There is no kindness, compassion or caring. Love does not exist. Sex, when it occurs, is as perfunctory and joyless as defecation. The only source of satisfaction is someone else's misery. Children are abandoned at age three. The sick are beaten; the dead left unburied. There is no religion, no ritual, no art, no hope, no rage, no sadness. There is only boredom, bitterness, envy and suspicion.

Are they psychotic? Residents of some forgotten back ward? Or is this hell?

Neither group is any of the above. They are, God help us, the same people, separated by two generations.

Read *The Mountain People*, by Colin Turnbull. It describes what happened to the Ik, a tribe of hunter-gatherers in Africa that was forced by progress and the Ugandan government to give up its traditional lifestyle and to remain to "farm" a single, desolate, drought-ridden area.

I do not believe it is possible to pursue the concept of madness until we understand what adversity can do to human beings. It is no more useful to assume that psychosis is innate than to assume that "humanity" itself is innate. What we like to call humanity is only a contrivance of social forces.

I cannot forget the Ik. I see them everywhere. They force me to perceive the malleability of human behavior and to see how arbitrary it is even to address deviance in a society that is not just.

With that introduction, I want to try to finish this inquiry into the meaning of psychosis. Let us assume that the labeling process and the isolation of the mad is a class-determined and otherwise arbitrary degradation ritual. Let us also assume that psychiatry's current fixation on biological determination is myopic and entrepreneurial. Still, there is something there. Even apart from the trauma and the poisonous drugs and all the other institutional attacks on the mind heading down the path of insanity, and even apart from the semantic stupidity that defines this path as "a disease," what is it? What happens? Why and how do people lose contact with reality?

Whatever it is—however you describe or define major mental illness, psychosis, schizophrenia, disturbed behavior or insanity—it is not a random event. It clusters, and its most obvious, most overwhelmingly characteristic feature is its relationship to urban poverty. Over 50 independent epidemiological studies throughout the world—including the classic studies of Farris and Dunhorn, Hollingshead and Redlich, the Leightons, Srole and others—have demonstrated an inverse relationship between mental illness and social class: the lower the class, the more cases of mental illness there are and the more severe they are.

On this continent, major investigations in Chicago, New Haven, Nova Scotia and Manhattan gathered a huge amount of information from interviews with samples of various populations. Independent evaluations of the behavior and complaints of family members and measures of social class all led to the same conclusion: the poor suffer more.

The tautological triteness of that statement contains more truth than volumes of theory about psychopathology. Sharp lines sometimes obscure reality. Our Western, scientistic and atomistic mentality has forced us to draw lines around the concept of poverty as distinguished from the concept of mental illness; this permits battalions of professionals to become obsessed with whether or not they are causally related. When you erase the lines or, as a Buddhist would say, drop the veil of Maya, so that ambiguities can be seen more clearly, you may come to the realization that behind the concepts of poverty and mental illness lies the same phenomenon.

What, after all, do we mean by poverty? Poverty is not so much a matter of possession in itself, but of a more subtle and significant affair: power. The poor have no control over the events of their lives.

There is more illness, more injury, more death, more pollution, more family disruption, more unemployment, more alienation, more crowding, more homelessness, more harassment, and more danger among them. Living in urban poverty is like living in a turbulent ocean, trying to hang on to a child with one hand and a sodden piece of driftwood with the other. There is a whole ecology of bitterness, envy and suspicion.

Melvin Kohn, in a 1973 publication of the National Institute of Mental Health, reviewing the data on social class and schizophrenia, tried to analyze precisely how poverty and insanity correlate. He concluded that not only is there more stress and fewer resources to cope with that stress among the urban poor, but there is also a *socially programmed* view of reality that transforms each stress into an emotional killer. His review of existing data and his own research indicate "that the lower a man's social class position, the more likely he is to value conformity to external authority and to believe that such conformity is all that his own capacities and the exigencies of the world allow." The more powerless a person, the more he or she worships power.

What, then, is madness? When you listen to and watch psychotic behavior for a long time, you may be struck by a dramatic constancy running through its kaleidoscopic variety. The first thing to observe, however, is that there is little romance to a psychotic episode. It is not like a scintillating trip through the sky with diamonds. It does not fling open doors to new worlds. It does not create a sisterhood with the Great Mother. Its anarchy is not that of the universe. A psychotic episode is more like a narrowing down, a closing off, a carelessness so deep that it is not so much that rules are broken as that they are no longer seen as things to be followed or ignored.

I watched a woman slip into madness recently. Her working-class, middle-aged life was buffeted by an abusive husband, an abusive son and a series of abusive supervisors at a succession of low-level jobs. She would come home day after day, year after year from her file-clerk tedium, exhausted by the subway commute and the stained city's air, only to begin caring for her indulged, soured men; with their impatient appetites and their bottom-rung entitlements, they waited for her like beasts in a lair.

She wrote poems in secret, a gift to herself. She got in touch with an inner life-yearning—compassionate, visionary, erotic. Horizons dropped to reveal more distant ones. Then her husband lost his job. He became even more demanding and self-centered. He insisted that she take a leave of absence from work and accompany him on a "vacation" to a grimy motel near a race track. For a week she stayed cloistered in the plastic cell of the motel, watching television and trying to keep a smile plastered on her face for her husband, while he squandered their meager savings. His last reserves of kindness disappeared with his vanished hopes for a "break" at the track.

She stopped writing poetry. Then she stopped dreaming. Then she stopped sleeping. She began speaking incoherently, muttering constantly just beyond what could be heard. Her husband told her to speak up or shut up or make sense or go to sleep or take a Valium or eat. He would not leave her alone, and the TV blared a counterpoint to his anxious nagging. He brought her back to see me, "the quack," when she began assaulting strangers in the street, shouting that she was being tortured, that her mind was being controlled by devils, that she was the Messiah and the forces of hell had taken up arms against her.

To what reality was I bringing her back when I gave her an injection of potent medicine? What use was it to her or, for that matter, to the world whose rules I insisted she again follow, that she denounce her feeble ecstasy as sick and alien, give it up for the capricious promises of poetry? Maybe someday I would tell her that I did not want her to be psychotic *because we are in this together*—because her powerlessness over her own destiny and her bulling husband's (and mine too in so much less a way) will have to be confronted by all of us some not-too-distant day.

In the meantime, it was my job to shut down the amplifiers of her too starkly stated truth.

I have come to see that all psychotic episodes are brutal parables of power. The content of delusions, the shards of disconnected thought, the seemingly senseless rage, the gesticulations and posturing, the whole crazy show revolves around issues of power and control.

The socially broken-down resident of a backward—rocking, mute and immobile—will become tormented or enraged when his or her few inches on a bench are intruded upon. Psychotic guilt, with its pacing and handwringing and brutal insomnia and obsession with devouring disease, is an attempt by the patient to pay him or herself back for fantasies of omnipotent destruction. Psychotic depressions are dark transactions in which angry wishes are punished with death as if thought had the power to kill.

And throughout all psychoses—whether from drugs, senility, sensory deprivation or that great semantic cesspool, schizophrenia—there is paranoia,

the caricature of power. It does not matter whether the paranoia is of a megalomaniacal or a persecutorial nature; its common denominator is always an exaggerated sense of power.

Paranoia is not so much the belief that the FBI spies on citizens as it is the belief that the paranoid is the primary target of the spying. The paranoid feels he or she is too important to be ignored by an all-powerful presence.

The persecuted paranoid is only an elaboration of the megalomaniacal one, who straightforwardly believes he or she is supremely powerful. Behind that belief lurks a nagging sense of invisibility, unaccountability and meaninglessness, as if one were an atom in the void—utterly, completely and relentlessly powerless.

The psychotic thus lingers on the threshold of Buddhist wisdom, but, in our culture's name, repudiates it. Paranoia is the reaffirmation of the culture's most cherished value. It is to power what looting is to property—a scary but ultimately reassuring statement by the have-nots to the haves that the object (power, property) is, after all, worth everything. *Madness is the final deference of the dispossessed.*

There is really little difference between the paranoid and the nonparanoid as they lust for power. They share the same values and purposes. They begin and end with the same singleminded, infantile demand for accommodation to their own wants. They insist that the world bend to their whim, and they refuse to heed its feedback. Ultimately, there is no difference between the man who thinks he is Napoleon and Napoleon himself. The fact that one is labeled mad and the other celebrated is a caprice of fashion and public relations, which is what macho-psycho-history is all about anyway.

Paranoid delusions are not random accidents of short-circuited neurophysiology or "sick" chemicals; they are the raw stuff of cultural ideology. Their slight hyperbole, like the postures of an arriviste, are what give offense. But the offense is hypocritical, as is the righteous indignation about crime by propertied people. Theft reassures the rich that everything they have is worth keeping; madness assures the powerful that what they have is worth holding on to. The poor and the powerless and the wealthy and the autocratic are all saying, "I want, I want."

Madness and proverty are not unfortunate side effects of a soceity preoccupied with power. They are essential to it. Once you celebrate power, you design a spiral nebula that flings people into a void. There is no demarcation between those at the vulnerable periphery and those closer to the omnipotent center. Everyone is trapped by the same violent constellation.

And yet there seems still to be a difference between the psychotic and the nonpsychotic. The Buddhist who has experienced the wisdom of Prajna and sees the essential unity of things will soon have a new vision, called Karuna, which permits distinctions once again to be drawn without losing sight of their illusory quality.

People become mad at a certain point. The cluster of these points when seen in the midst of the big picture helps define the culture's reality. But each point resides within a tormented individual who cannot be ignored, despite the compelling truths of public health, politics and philosophy. Although a pencil line's sharpness is revealed as tufts of clouds and points under a microscope, concentrating on the mysteries of the line does not eliminate the points.

So one keeps looking for the connections between the general and the specific. One tries to find out how the culture's madness becomes manifest in the individual.

Major studies at the Maudsley Hospital in London over the last two decades have shown that just prior to a person's having a schizophrenic episode, there was an increased frequency of adverse life events. Psychosis seems to emerge when an individual cannot withdraw from a family system of intense emotional expressiveness, which amplifies those events. I have watched this happen over and over again. Feeling at the center of the world's pushing and shoving, depleted of any sense of control, trapped in an overstimulated environment, the individual becomes overwhelmed and lets go. The line between the inside and the outside is lost. Opposites become the same. Wishes and fears merge. Perception and fantasy roll over and then through each other. Screams of terror bubble into silly giggles. Waves of paranoia wash over the ego, dredging up bitterness, envy and suspicion. There is a limit to what people can stand.

Madness has not been consigned to humanity by providence. It is an artifact of society's power arrangements. The assumption that it is found in all cultures at all times is a rationalization for not looking at madness in the Western world now. Besides, the assumption isn't true. A review of anthropological literature by E. Fuller Torrey for the National Institute of Mental Health concluded that the alleged universality of schizophrenia does not stand up to close scrutiny. In many "primitive" societies, for example, schizophrenia seemed to appear only after the people were reached by urban, industrial expansion.

There is a scene in *The Mountain People* that strains and screams at the frontier of sanity, and thus seems to establish it. An old and injured woman has been left struggling at the bottom of a ravine. Turnbull himself, having observed that the only reaction of the women's people was to watch her death with amusement, decides to carry her back to her hut. On the way the woman suddenly bursts into tears. Turnbull, astonished by the sound of grief, asks what the matter is. Between sobs she says that his kindness suddenly reminded her of what the life of the Ik used to be like.

It is not, after all, very complicated. Whatever madness is, it is deeply rooted in social and sexual inequality. Without a cultural revolution we will continue to have madness; as the contradictions of capitalism become more intensely chaotic, we will have more and more of it. There will be no cure for schizophrenia any more than there will be a cure for cancer. There will be no relief from our common misery until we step back from the technological abyss and redirect the course of history.

A Teacher Responds

by Pamela S. Warren
Classroom Teacher,
Des Moines, Ia

Dr. Drummond's article aroused several responses in me — many have been emotional, intellectual — *and* confusing. I read his articles over a month ago. I was very excited as I read this articulate plea for a humanistic perspective on the part of mental health professionals.

Drummond covers most of my frustrations with very creative and vivid descriptions. Yet I almost feel a professional obligation to disagree with him, using clever and maybe scathing comments to dispute him as being idealistic and not in touch with "reality." Reality being, of course, that we live in a society where everyone knows there is no such tangible as "normal," but there *are* tangibles of "abnormal." Our jobs deal with trying to change the "abnormals" to behave less abnormally so that they'll blend in with the rest of us; so they won't be so threatening and potentially dangerous to society, to themselves, and to us by constantly reminding us that there really isn't such a thing as "normal." I was going to dispute Drummond, wasn't I? I guess that would end up being a very feeble effort.

The beliefs on which I operate are:

I believe that individually and collectively we have the potential for creating our own reality (or realities). Now, obviously, as a group (sometimes known as "a society," or "a culture") we have had to arrive at some mutually agreeable rules so that we can live together. To simplify things a little, the planet has provided some significant "givens" which offer universal reference points: time and space. Beyond those two, it's up for grabs. Now the process of defining societal reality didn't happen overnight, and it hasn't happened without a lot of struggles. (In fact, groups are still struggling with some key issues of the first draft. Sometimes they even get so frustrated that they become violent and have riots or wars). Because there really are only two hard core given reference points or rules, and because there are as many opinions of what rules or values we should all adhere to as there are individuals, we have a problem. The current draft of reality under which we really are trying to live is held by some to be a major and respectable work. There are many, many people who have such intense emotions invested in this reality of ours, that they get really bent out of shape when an individual doesn't follow the rules. It not only makes them frustrated and angry, but scared. They are afraid because maybe if somebody doesn't follow the rules of Reality, it'll catch on. Or they may even be saying this Reality isn't right — or at least it doesn't fit them in their given circumstances. My conclusion is that reality is relative.

My second major operational belief is that there is no such thing as abnormal. . . .or irrationality. . .or crazy. We are all "crazy" — in different ways, at different times, under different circumstances — all depending on our coping skills and our abilities at any given moment to love ourselves and others. I believe that every behavior, no matter how it is perceived by others, is a rational behavior. We may not know what another person's perception of reality is — *they* may not know what their operational reality is — but it is there.

I believe that my job working with emotionally disturbed children-and *our* jobs working in the broad mental health spectrum — is to help individuals figure out what form of reality they are operating in. Example: I feel far more comfortable with negative attention than positive. I can predict and control people's reactions to me. When I can do that, I feel safe. I am operating in a reality that has, at its center, the belief that I deserve that kind of treatment and abuse; that I am not worthless if I can at least get negative attention. That's my reality. No matter how bizarre or irrational my behavior seems to others, it really isn't to me. To me, it fits. It not only fits for today, or for this particular situation, but it just may fit for all situations. I may not understand or know any other reality.

Our job is also to help individuals to see that their given set of beliefs form their reality. Their reality isn't the only reality. Others have created different realities — and societally we have tried to come up with a mutually satisfying one. That's not to say it's a perfect one — it doesn't always work or make us feel very good. But it's o.k. for us to know that, to be angered about it. That is also where we have choices. One choice we all have is to totally reject group reality and to make one that fits us alone. That isn't necessarily going to solve the problem of our unhappiness or loneliness. There are other realities we can create for ourselves that still acknowledge and accept enough of the group reality to remain a part of the group and can make us happier, more satisfied and loving individuals.

We must help individuals find a reality that is mutually satisfying to both them and the group. This is the part with the major emphasis on changing specific behavior and helping someone understand *why* it's important to change some behaviors.

The problems with mental health aren't just with the professionals working with "crazies" or even with the "crazies" themselves. The problem is that both the "crazies" and the mental health professionals are a major reflection of societal problems. Societal problems (all of them, and not just *American* societal problems) are a reflection of *human* problems. I don't know if they're really any worse than they've ever been. What frustrates, saddens, and scares me is that I don't think they're really any better. I don't think we've really made any overwhelming strides in helping each other deal with the human condition. Sure, now we have psychiatry and all the other mental

health services along with social services and medical services and everything that science and technology have given us, but I think all of that is more like having one heck of a cold and just continuously wiping a runny nose. Wiping it doesn't stop it from running.

Instead we seem to be perpetuating a lot of the same old problems. Occasionally we make a stab at re-defining the problem or the solution. Now we have an abundance of sophisticated labels to identify the problems — and an overbundance of catchy-titled treatments. We now even have a law that mandates we identify (label) and provide free, appropriate treatment with all sorts of guidelines. We appropriate monies, train and hire personnel, provide programs, and treat. Or do we? Sometimes we really do. Sometimes we really get down to deal with human beings humanistically. Sometimes we are truly feeling, caring, and helping. And that is indescribably exciting! And what's really exciting is when we really do help someone we increase our understanding of the human condition. Unfortunately we don't really do that much very often. Most of the time we're just wiping noses. . .other people's and our own.

Drummond isn't the first, and he certainly won't be the last, who has been witty and sensitive in describing the problems. Maybe it *is* all a power play. Maybe it's all born out of fear — fear of being contented, happy, lovable, and loving human beings. So we play power games using each other as pawns to continue the charade that *we* are normal, healthy, fulfilled human beings. Maybe that's exactly what we are afraid of. Maybe that's why we criticize the "system" (and for every system there are innumerable sub-systems); it's *their* responsibility — or even *his* or *her* responsibility. Why isn't it ever *our* responsibility? Why do we always distance and objectify the kinks in the system? Why don't we ever take responsibility and do somthing about it in terms of "*my* responsibility". . .or "*I'm* going to do. . ." (or at least try)?

It seems to me that one place to start would be in the schools. Instead of identifying, labeling, segregating, and then mainstreaming, why don't we start "treating" everybody? "Treating" or "treatment" doesn't have to imply "abnormal." Imagine the impact if "all" classes were no more than ten children. If that were to happen, we wouldn't need to segregate the kids with the problems. We might possibly lessen the numbers and intensity of the problems caused by academic frustrations and emotional problems. Providing teachers with the time to give caring attention to individuals can change things to an amazing degree. What's that? That still wouldn't address the *family* problems? *True.* But it would be a start, with incredible implications (including *family* problems) a few years down the road. Families are made up of individuals. Remember? What's that? Cost factors? Practicalities? Realities? Oh, yes — excuse me, please. I forgot. Let's just go back to wiping noses.

A Child Psychiatrist Responds

by Martha E. Ehbrecht, M.D.
Child Psychiatrist
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I read the two articles by Dr. Hugh Drummond. I have never heard about a magazine called *Mother Jones*, nor have I heard about a book called *The Mountain People* by Colin Turnbull.

I find many exaggerated, unrealistic remarks in the first article. What do sentences like this really mean? "There will be no relief from our common misery until we step back from the technological abyss and redirect the course of history;" that is impossible. I know there has been some social approach to mental illness, but not all of the deviations are due to social differences. Also, I don't think that all psychotic episodes have something to do with power. Sometimes I wonder why people like Dr. Szasz, who don't believe in mental illness, are chiefs of psychiatric departments and are doing things they don't believe in.

It is part of the difficulty of American psychiatry that psychiatric illnesses of indigent people are treated in state-provided facilities. This is not the case in any other country, except maybe Russia,

What I saw when I entered this country twenty-six years ago was that not much money was spent on the treatment of indigent mentally ill people in state hospitals. Therefore, the treatment had to be poor. This was not the fault of psychiatry, but of legislators and other irresponsible people. One psychiatrist for five hundred or a thousand patients just cannot do the job.

As far as pharmaceutical industry is concerned, drugs may not have completely helped, but they made a difference in mental hospitals. I happened to come to Cherokee in 1954 before the use of tranquilizing drugs. The work with mentally ill people contained a great deal of aide abuse and fighting with patients. This was completely eliminated by using drugs. Many of the hospitalized people could live outside of the institutions and some of them could function productively with the help of drugs. Whether all of their delusions or hallucinations were stopped by drug use is questionable and really not that important. Up to this point, unfortunately, we do not know the reasons for mental illness, which is one of the biggest handicaps in dealing with it.

Psychiatry is one of the oldest branches of medicine, and I think it has been dealt with in an objective and open way by most psychiatrists. It is seen somewhat differently in the United States than it is, for instance, in Great Britain. No matter how you look at it, there seems to be a certain amount of people who need help with their emotions and with their inability to think logically, and I think these people should get the help if possible. I have worked in state institutions and I have worked in private practice, and I think the need in both places is the same.

An ED Consultant Responds

by Ellen McGinnis
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Children are people despite any extra label placed upon them by well-meaning adults. For some reason, we lose sight of the child when a label is attached. He ceases to be perceived as a person. His uniqueness and individuality are lost or viewed only within the dimensions of his deviance. The child grows to be considered first and foremost Emotionally Disabled.

My primary concern is that the label, Emotionally Disabled, has stigmatized children and, though necessary for funding purposes, does not communicate information regarding the child's specific needs. The present term ED implies that a disturbance exists within the child, that he is "disabled" by his "emotions". I contend that this label has served to cloud our understanding of children as whole people who are much more alike than different from "normal" kids and who are very different from each other.

Drummond addresses this issue in the more global arena of adult mental health services and discusses 1) the medical implications of "mental illness"; 2) the self-fulfilling prophecy of labeling; 3) the role of power and poverty in "mental illness", and 4) casual psychiatric diagnosis. His views support my concern about the hazards of labeling school-age people.

Power and Poverty. . .A Phenomenon?

Let us first consider Drummond's thesis "that madness is a function of power in our society and to declare that madness resides solely within the individual is the power elite's lie." I agree that an emotional disability, as we in education have come to interpret "madness", does not exist within the individual alone. We cannot consider a person's behavior isolated from society without regard to past learning and cultural influences.

Yet, these factors may not even be considered when thinking of a program placement for a child. Within the framework of education there exists what is called a "hidden curriculum" (Chan and Rueda, 1979). This is the assumption that all children enter the school setting with similar experiences and values. It is expected that a child will possess certain cognitive skills developed by the exploration of his environment. It is also expected that he has within his repetoire a set of student behaviors enabling him to appropriately respond to adult instructions. Education further assumes that each student will be motivated to attend and achieve. This is without regard to the possible lack of early language experiences and appropriate models for behavior. The school community fails adequately to recognize that a child's environment may not value formal education. This often contributes to the child being labeled Emotionally Disabled when his "emotions" may have little to do with his severe problems and his "disability" may vanish when he has been directly taught what he could not pick up from his environment.

Power, defined as "the ability to do, act or produce", does exist within the framework of our society, and those individuals or groups in control of their own lives exert their "power" in controlling others — legally, medically and educationally.

Individuals confined to a mental hospital do not have control over the events in their lives. In the institutionalized setting, the individual is "powerless", and as Drummond says, in the mental hospital "a 'good' patient accepts his powerlessness," he follows the rules designated for him.

This, also, is true in the school environment. "Good" students are well-behaved and follow the regulations set by the school's administration. For school survival, a child must behave in accordance with distinct classroom rules. Within the dimensions of the school community there are also other sub-environments of special interest classrooms and social settings. The individual must possess the capability not only to follow a set of expectations, but to adjust his behavior across the variety of settings. For example, the actions of running and shouting are acceptable in the social world outside the school building (e.g. the playground), but will be considered abnormal when they occur within the classroom itself. When a child is labeled ED, there too often has been little regard for these adaptability factors or for the influence of the teacher/child relationship, the effectiveness of the classroom program, or individual levels of teacher tolerance (Hewett & Taylor, 1980). But it is the child who bears the stigmatizing ED label, not her neighborhood, or her school, or her teacher — who may be the one who has been "emotionally disabled" by a situation he has not been trained to handle!

Drummond contends that "persons in state mental hospitals have poverty in common." In classrooms for youth labeled "emotionally disabled" there are a predominant number of students that come from an economically deprived environment. Sometimes individuals from higher socioeconomic families may actually be denied appropriate services due, perhaps, to the stigma and embarrassment attached to the labeling process that people are unwilling to subject children from "good families" to. It is much easier and more acceptable to label a child who is from a lower socioeconomic group ED.

Drummond contends "the more the doctor likes the patient. . .the closer they are in social class, the more likely he is to diagnose the patient as neurotic rather than psychotic." The same phenomenon exists within education. It may be caused by these families' lack of

control or powerlessness, their values which differ from those held by the majority of people in education, or by other influences such as personal hygiene and poor nutrition. The answer to Drummond's question "do the poor suffer more?" is certainly, by middle class standards, yes. Their hardships and deprivation lead to their more frequent designation as Emotionally Disabled.

Psychiatric Diagnosis

Historically, "mental illness" has rested within the confines of medicine, expressed in medical and psychiatric terminology, and treated with surgery and drugs. Rhodes and Paul question "why were the problems in living, in adjustment and adaptation, moved into the providence of medicine?" I feel that this is a question Drummond, too, is asking. Perhaps it has to do with our fear of dealing with behavior that we do not understand, thus leaving this area to the expertise of a trusted profession. However, "illness" reflects the assumption that we are dealing with discrete disorders which are quantitatively, qualitatively and consistently different from "normal". I do not believe this is true.

The label used in Iowa for behaviorally handicapped students is Emotionally Disabled. This label implies that a disturbance exists "within the child".

Drummond states that psychiatric labels are easily given to those persons who have broken some rules of propriety. I sense that we as a society unnecessarily feel the need for labels, for classification systems which place behaviors in neat, specific categories for social structuring and communication. This is done with the hope that we will then be able to find the cause and provide a "cure".

It is easy to become caught in the use of labels for communication. At our present level of sophistication, when a referral for an evaluation is needed, a specific diagnosis is the outcome that is expected and is usually received. However, too frequently the accurate communication of specific behavior and need becomes lost, and all that is conveyed is a label.

Drummond makes reference to the unreliability of diagnosis. I know that some diagnoses are made from the fact that a drug was tried and was found successful in reducing a target behavior. For example, if a major tranaquilizer used effectively to treat cases of a "thought disorder" reduces the individual's obstreperous behavior, that individual then may be referred to as having a "thought disorder".

Recently, I have participated in contacts regarding school children where a specific "pathological" label has been justifiably avoided by the psychiatrist and instead, specific needs and interventions have been suggested.

In the past several years, education and counseling practices in general have moved away from the "medical model". More consideration has been given to the study of the interaction between the individual and the environment - or ecosystems. From this viewpoint, "emotional disturbance" is not seen as existing within the individual, but rather is examined in the context of the child and the various ecosystems in which he participates — the home, school, peer group and community (Hewett & Taylor, 1980).

I sincerely hope that these trends away from using specific psychiatric diagnoses as education indicators become stronger and more pervasive. When considering a diagnosis, the following quesitons must be asked: How will this help the individual? Will people cease trying to make needed changes in the child's environment due to this label? Will others view the child as behaving in a certain manner because that is the way those labeled as such behave? These ar. .he kind of questions we must ask when a diagnosis is to be requested, or when we are in a position to commensurate a child's diagnosis to others.

Medical Implications for Programming

I support Drummond's contention that "rulebreaking (mental illness). . . exists in a larger sense than neurophysiology." However, I also believe that medical research must play a part in the exploration of "mental illness", and in determining the efficacy of drug therapy.

Prolonged use of some medications, as well as withdrawal from certain drugs, produces behaviors similiar to "emotional disturbance". Additionally, with some personality changes, medical factors such as metabolic disturbances have been discovered.

Drugs are ordered by the physician, but because it is the teacher, not the doctor, who holds the responsibility for teaching academics and behavior alternatives to the medicated child, this issue must also be considered within the realm of education. The use of drugs to control behavior of school children and adolescents is not uncommon. Perhaps this practice exists because these difficulties historically have been viewed as illnesses. This orientation, as well as the discovery of many new drugs which offer positive possibilities for appropriate treatment, have created a climate in which drug misuse also occurs. I believe the use of drugs for treatment is easily abused by the high dosage and frequency with which they may be prescribed, and by the misunderstanding of parents and teachers of their responsibilities for careful administration and monitoring effects.

I cannot deny that medication can serve to reduce the intensity or frequency of a student's deviant behavior. Neither can I argue against prescribing medication to, for instance, an adolescent who seemingly has "lost touch" and is beset with fearful hallucinations. As Drummond concedes, "the only way to maintain ideological purity about drugs. . .is to avoid contact with people who are psychotic". It is my contention that there is no need to maintain ideological purity. Instead, while the administration of medication may be explored, it must not become the only therapy. Much too frequently, medication is the only intervention attempted for behavior change. As teachers, we must be responsible to use the tools we have in our professional grasp — a classroom environment we can structure, a set of academic skills we can use to develop children's competency, a vast

array of direct instruction techiques we can modify to teach social skills as well as social studies.

Drummond states, "when something is seen as 'genetic' (organic), it becomes fixed in the mind as inevitable. . ." Organic factors are viewed in this manner. Yet, in special education, we have not become fatalistic when regarding the capabilities of a child with Down's Syndrome, for example. Instead, we go to even greater lengths to prove that stimulation from the child's environment does, in fact, yield greater achievement for that child.

Last night at an Iowa Society for Autistic Children (ISAC) meeting, an assessment checklist was described. One mother looked it over and commented that she wondered if her son would even qualify now for the label "autistic". Most of the terms named things that had been problems when he was younger, but now, by hard work at home and at school, were so diminished they hardly seemed appropriate to check anyone. Autism is the rare thing in our "ED" world, a life-long disability, and Bobby is and will remain autistic. But, such is the power of teaching that he has grown and developed and flourished. The label tells us "what he is" and suggests ideas for helping him. Bobby tells us *who* he is and how very much he has learned.

Autism, once considered a form of childhood schizophrenia and treated by psychotherapy, is believed to have organic causation; education, however, is the treatment of choice.

The Stigma of Labeling

Drummond writes of the "built-in double-bind" of communication within a mental hospital. Psychiatric therapy, by design, encourages one's communication of wants and needs, and yet, these expressions may not be accepted as meaningful. Instead, they may serve to support a view of "illness", "deviance", or pathology. We perceive words spoken from someone labeled "mentally ill" as quite different from the same expression of needs from someone we do not see as "disturbed".

Likewise, a "disturbed" student's expression of needs is viewed quite differently than an unlabeled student's expression of anger. If the labeled child is involved in playground conflict, it most often is perceived as a result of "his problem", whereas a "normal" student's misbehavior is viewed within the context of the conflict situation. The words and misbehavior of a "labeled deviant individual" are, in a sense, perceived as a "symptom" of his "illness", rather than an expression of his needs. It is often the case, for instance, when two children are engaged in a physical confrontation, the "labeled deviant" will be found at fault.

The articles by Drummond describe life within a mental hospital. Let's look at life within the schools.

In some classes for Emotionally Disabled children, the regular classroom curriculum is used. Instruction is provided by essentially the same methods and materials which failed them in the regular classroom. The differences are that there are fewer students in the ED class and most often an externally administered management plan is in operation. Little or no instruction may be provided to help the child unlearn his self-defeating responses. In other classes, the individual teacher provides specific instruction on how to deal with frustration and problems through group and individual counseling and the implementation of behavioral contracts. However, even within this special class, too often the practice of "treating everyone alike", is the constant goal.

In such classes for Emotionally Disabled children, too often the individual is lost and the child, instead, is viewed primarily as Emotionally Disabled and treated as part of "the ED class" — "and you know how those kids act!"

I have seen greater restrictions or insistence of powerlessness placed on students in classrooms for Emotionally Disabled than on "normal" children. These kids are expected to stay in their seats for longer periods of time, behave more normally, and accept more severe consequences for their behavior than same-age peers in regular classrooms.

Drummond says: "While the label is affixed with ease, it can never be removed." This also is quite apparent in the education of deviant students. Teacher attitudes toward an individual child change when she "becomes" officially through a staffing. Perhaps adults feel unequipped to deal with children with this label, with all its medical implications. Perhaps, too, we become fearful in dealing with disabled "emotions" and the mysterious lack of control that is implied by this label. Many teachers have learned to work effectively with special education children with other handicapping conditions, but are apprehensive, reluctant, and afraid when presented with a child who is or has been called Emotionally Disabled. The concern of the continued stigma perhaps is best verified by the smaller number of labeled students who return to a regular classroom on a full-time basis.

My contentions regarding the damaging process of labeling and serving this population is best expressed in the case of Mark. Mark is a twelve-year-old boy identified as Emotionally Disabled. He lives with his mother and younger sister in a poverty sticken area of town. His mother has difficulty dealing effectively with his actions and she therefore allows him to do as he chooses. There are no books in Mark's home and there is no money for recreational activities.

In the school classroom, he is one of seven students. He is frequently late for school because he has overslept. His physical appearance can be described as unkempt and he expresses his embarrassment regarding the clothes he must wear. Academically his skills are below his grade placement in all areas, and much of the time he refuses to complete his assigned tasks. He spends his day within the confines of this setting, denied lunchroom and recess privileges due to lack of academic performance and disruptive behavior. Mark occasionally loses control, expressing his anger by pushing over his desk, throwing his books and crying. When this occurs, he is physically restrained and moved to a time-out cubicle. He also spends time in this isolation area for other behaviors such as the use of profanity and academic refusal.

Mark's tasks for the day consist of reading, math

and language arts, though he may work on a model car or jigsaw puzzle when this work is completed and any errors are corrected.

There is little joy in Mark's school life. He sees no reason to read a book or to learn to write neatly. He has never experienced the intrinsic joy of learning.

This is not a fabricated tale of a child or situation. Mark and his circumstances are real. The presentation of this example is not made to lessen the fact that there are many loving and joyful classrooms for Emotionally Disabled students where caring teachers are sensitive to the needs of each child. But, in Mark's case, education has lost sight of him as a unique individual and has disregarded his environmental influences. I believe this happens because ED teachers themselves are subject to the same fears and biases as other educators, and that they have never been trained in the techniques that will allow them the rewards of experiencing their ED students as likeable, learning kids with unique problems and potentials. If the school insists that such kids accept its values, not by the means of teaching these values, but rather through its power system, Mark is, and most likely will continue to be viewed only within the dimensions of his deviant behavior.

The views focused upon by Drummond support my contention that the labeling of a child as Emotionally Disabled does not increase our understanding, but serves to obscure our insight into the individual. I believe that the label Emotionally Disabled inaccurately implies an innate disorder, isolated from environmental factors and learned behaviors. I believe the field of special education must not continue to foster these assumptions, but press on in its pursuit of educationally and emotionally nurturing plans for those people who are children with problems.

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A Psychologist Responds

by Rick Jennings, Ph.D.
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I shall respond by first discussing Drummond's central theme, power, followed by a discussion of the issues surrounding the power phenomenon; the child patient issue, the psychotic patient issue, the medical model issue and the in-patient versus out-patient issue. I shall speak to the psychological and social issues as manifested in the current psychiatric approach of which Drummond is so critical. I shall not comment upon the manifestation of these issues within the specific context of psychoactive medication due to my lack of expertise in this area.

Power

While the power phenomenon cited by Drummond may be socially and politically engendered, it is manifested and maintained within each individual doctor*-patient relationship. Like issues of environmental pollution, its existence has been well known for years but has only recently gained attention as the media winds of "The Cuckoo's Nest" has blown the stench in the public direction. More than 35 years ago Antonin Artaud, French author and playwrite, closed his "Letter to the Medical Directors of Lunatic Asylums" by stating "Try and remember *that* tomorrow morning during your rounds, when without knowing their language, you attempt to converse with these people over whom, you must admit, you have only one advantage, namely force." (Ruitenbeek, 1972). Drummond's central theme is thus not new. This only lends credibility.

In psychiatric treatment the "doctor" occupies and maintains a position in which he is protected from challenge and criticism. This protection is rarely examined or discussed and is so automatic and complete that it frequently goes unrecognized. It is legitimized as "the doctor knows best" or defended as necessary to expedite psychiatric treatment and/or smooth institutional functioning. When the patient disagrees, it is not because the patient has a valid contention, but rather that the patient misperceives or misjudges as a function of his illness. After all, if the patient perceived and thought clearly, he wouldn't be a patient. When psychotherapy doesn't help, it's due to the patient's resistance. When the patient disagrees with the motivation which the doctor assigns to him, that's because the actual motivation is unconscious. Improvement is due to the doctor. Regression is due to the patient. When a patient states "This is not helpful" it is not that the patient may be correct, but rather that the patient obviously does not know what is helpful. A hospitalized patient who states "I don't need to be here" obviously does need to be in the hospital. After all, he's so sick he doesn't know he is sick.

There is literally no equality in doctor-patient transactions. The patient has no power and, as Drummond so aptly points out, "Good patients accept their powerlessness". As a matter of fact, one might question whether a patient who improves is moving toward normal, socially appropriate behavior or toward a demonstration of his acceptance of powerlessness.

Drummond exposes the irony of attempting to treat individuals who have developed psychiatric symptoms resultant to having no power by placing such individuals in a psychiatric facility that strips them of their remaining power. While such a realization is painful, Drummond has provided us with a powerful, two ingredient analgesic; he has limited his discussion to adults and to the psychotic patient population.

The Child Patient Issue

While Drummond speaks of adults, who is more easily taught powerlessness or helplessness than children? From an environmental perspective, a child has negligible power over his socioeconomic status, residence, school, parents and most other impacting factors. From a psychiatric perspective, any credibility or power which the child patient may have had is stripped by the label patient. It is one thing to label, confront, criticize and medicate an adult. It is much easier with a child.

It has long been my feeling that the major factor discriminating between those persons "making it" in our society and those not, is the simple but "powerful" attitude along the dimension of "does what I do make a difference?". Does "what a child does" make a difference in his parents' alcoholism, their divorce, their poverty, their "mental illness" or in the inflexibility of a classroom, "burn out" of a teacher, or the hole in his shirt that begets the condescending glances? And then can the petty thefts, the vandalism, the physical assault on the teacher, the runaway, the overdose of baby aspirin, the school refusal or encopresis be viewed as attempts to "make a difference"? And, most importantly, does the subsequent label "E.D.", or "patient" and the locked door, the medication and forced confrontation and all of the psychiatric power plays cited above convey to the child that his behavior makes a difference?

*Excepting that section of this response dealing specifically with "the medical model" the term "doctor" as used throughout this response refers to any mental health practitioner functioning as a primary therapist, regardless of the academic degree or speciality of that therapist.

In the psychiatric treatment of children, as compared to adults, the "power plays" which Drummond describes are more easily implemented and have greater psychological consequence. Under the defense of "researchers don't have to deal with the patients", psychiatric hospitals frequently and conveniently ignore highly relevant research of direct and obvious applicability. Such is the case with the findings in learned helplessness by Seligman (1975) and his colleagues. This research convincingly links the environmental induction of helplessness to clinical depression. Such an induction is basically a resulting of causing individuals to repeatedly experience their initiative and efforts as ineffective and inconsequential. This seems a strong parallel to the concept of powerlessness which Drummonds sees as so important to its sociological and psychiatric interplay.

While it is so easy to see the powerlessness taught in rigid child psychiatric programs, the most complete induction of powerlessness may come within our many private psychiatric units in which the total permissiveness translates a psychiatric hospitalization for a child into a trip into irresponsibility, reckless abandon and short term, manipulative and ineffective power. A psychiatric hospitalization and a trip to Adventureland should not be one and the same.

Drummond speaks of the induction of powerlessness from a sociological perspective. For a child, this translates also to a family perspective. Most of us working with E.D. children, upon reviewing such a child's social history prior to hospitalization, have commented "With this history, it would be strange if this child didn't have problems". The family is the problem, but we don't hospitalize the family, we hospitalize the child. That's the induction of the powerlessness. I have frequently wondered what effect *family* hospitalization would have upon the length of stay.

The Psychotic Patient Issue

The second ingredient in Drummond's analgesic approach is his exclusive focus on psychotic patients. Drummond's criticisms of the present psychiatric approach are *least* powerful when applied to the psychotic population where "the doctors" are able to defend their approach on the basis of the patient's loss of contact with reality and potential danger to themselves or others. Criticize the use or misuse of thorazine all you wish, but when it's your knee that's being bitten, or the 8 year old's head that is bleeding from being beaten on the wall, or the 14 year old's weight that has dropped to 62 pounds, it is a different story. When you're the psychiatric aide who is being strangled, or you're seen by your paranoid neighbor as tapping the phone lines and deserving execution, the medication suddenly becomes a miracle drug and not a psychiatric poison. We criticize psychiatry and psycho-active medication until the chips are down. We damn the psychiatrist who "locks people up" unless those people endanger us and then we call the doctor.

The problem is *not* in the appropriate use of medication, hospitalization, or confrontation, or even control. The problem is precisely one of over-generalization. Estimates place the number of hospitalized psychotic children as less than 5% of the child clinical population. My recent check with a large state institution indicated only 22% of all admissions for the month of August 1980 were burdened with a psychotic diagnosis. The point is that the power given to the doctors in their treatment of all patients is legitimized and based on their need for power in treating psychotic patients. It is a problem of over-generalization and faulty justification. Hospital policies are not based on a discrimination of psychotic and non-psychotic patients. Neither is the power of the doctors. A patient is a patient regardless of diagnosis. Patients need doctors and doctors need patients. There is a great profit in mutual role validation.

And "the doctor knows best". Just because the psychotic patient may need the doctor to know best doesn't mean the other 80% of the patients who are non-psychotic need the doctor to know best.

The Medical Model

Drummond's focus on psycho-active medication as a power issue is excessively narrow. The power plays potentially cross all aspects of the doctor-patient relationship, whether on an in-patient, out-patient, or educational basis. However, in his focus on psycho-active medication Drummond sets the stage for a critical finale which he never enacts: the efficacy of the medical model.

Is it possible that the doctor-patient power plays which Drummond sets forth are merely an effect of molding problems in living and growing into a disease entity? Drummond elucidates the illogic in psychiatric research bent on establishing a biochemical basis for schizophrenia. This is a good point relevant to 20% of hospitalized adults and 5% of hospitalized children. Drummond doesn't speak to the lack of a biochemical basis for tipping over desks in school or a germ theory of school phobia. Werry (1965), in his skepticism of the restriction of the practices of psychotherapy to physicians, coins the term "irrelevant M.D.". Szaz tells us of the "myth of mental illness". Yet we somehow continue to feel that since there is *some* evidence of a biochemical and genetic component for a *few* serious diagnostic categories, *all* behavioral difficulties are in some mysterious way medically based. And, the medical doctor "knows best". I contend that such an irrational logic places the patient, the doctor and the hospital in the power play which Drummond describes. Unchallengeable power is a great hiding place for both incompetence and professional impotence. A medical student who found himself in the role of psycho-therapist while on a psychiatric rotation with children once told me, "The child wanted to talk about running away. I don't know anything about running away, but if the patient is a patient, I must be the doctor." That's power!

Being a patient can be a great hiding place, too (as can being an E.D. student). One cannot help being

sick. The medical model is pathologically based; it studies what is wrong and in its domination precludes a study of what is right. It studies how people "get sick". It doesn't study healthy people and how they stay healthy.

Drummond is right. Psycho-active medication is a source of power, but the problem is that in some way the power to control some types of behavior with drugs magically makes all behavioral problems the province of medicine. While psychiatry has the highest suicide rate of any profession, supposedly due to overwork and over-involvement, psychiatry is also the primary force in maintaining its own dominance in areas of medical irrelevance. Perhaps the high suicide rate should be considered a function of a depressing professional impotence, for while those of us in education, social work and psychology jealously criticize the MD's, when the chips are down we run to the protection of that degree. After all, anyone who pays such a high malpractice insurance premium must be capable of great responsibility.

The In-Patient versus Out-Patient Issue

Drummond emphasizes the power plays within psychiatric hospitalization. This is also a worthwhile but excessively narrow perspective. The control in out-patient psychotherapy is decidely less, but the doctor-patient roles and power transactions are the same, and legitimized by the same over-generalizations and circular logic. We perpetuate the negative status of coming to the clinic by viewing patients (child or adult) as "sick". Our professional impotence is obsured by our "lack of control of the environment". We send Johnny off to see the doctor once a week whether he wants to go or not, where he is all too frequently patronizingly compliant and increasingly frustrated that his environment does not, and is not, forced to change.

Conclusions

It is all too easy to point out what is wrong. Drummond has done a nice job of it. So have Rosenhan (1973), Laing (1968) and Kesse (1962). I have also been critical, but such criticism is desperately needed when we have so heavily invested in and accepted such as a powerful treatment model. I feel the powerlessness which Drummond described is being taught, particularly to child patients on both an in-patient and out-patient basis. I feel most of us perpetuate this out of ignorance and unawareness and not out of malice. And I know of "doctors" who have become aware and who are incredibly helpful. But in general, Drummond is right. We must sincerely regard patients as people and not as commodities necessary for the economic perpetuation of hospitals and clinics. We must regard most problems of living and growing up as germ-free. We must realize that the ultimate "doctor" for many children can be a teacher or a counselor or anyone who is well trained and skilled in helping with such problems. Until we do, the induction of powerlessness will undoubtedly continue.

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An Educational Consultant Responds

by Clay M. Starlin, Ph.D.
Educational Consultant
Baton Rouge, Louisiana

It is rare to find an educational publication that is unencumbered by esoteric and pedantic editorializing. Carl Smith has provided such a format in the Iowa Perspective. I would like to thank Carl for having the courage and insight to create and maintain such a forum.

To Sandra Barbay and Sharon Turner, my warmest thanks for their secretarial skills and their concern and patience.

Introduction

I have graduate training in emotionally disturbed education and psychology and have taught and consulted in the area of the emotionally disturbed. However, what is probably more profound in terms of my response to Dr. Drummond's articles is that I have experienced a psychotic episode. Consequently, my response will draw from my professional and personal experiences with mental illness.

I basically agree with Dr. Drummond's analysis of the causes of mental illness and his concern about the damaging effects of many of our present treatment practices.

I strongly disagree with the implication that a sizable portion of mental health professionals are malicious and purposely inhumane in their professional conduct.

The vast majority of mental health professionals provide treatment they assume to be in the best interest of their patients. There is, unfortunately, often a great deal of difference between the **intent** of these practices and their **effect**.

Persons trained in various professional disciplines practice procedures they were trained to use. When this training, as in the case of mental illness, has been based on inaccurate perceptions of the causes and treatment of mental illness, the treatment is inappropriate, not because the treatment personnel are unethical, but because we have an inaccurate picture of the process.

There is and has been a "state of the art (science)" problem in mental health training and practice. This can be seen in four fundamental failures: (1) failure to precisely define what behaviors distinguish "mental health" from "health illness", (2) failure to establish quantitative "normal limits" and "abnormal deviations" for these behaviors (analogous to the physical normal limits used in medicine), (3) failure to identify tools to accurately and reliably measure change (improvement or decline) in these behaviors and (4) failure to **constantly question** and change the diagnostic and treatment procedures, as long as rapid and permanent cures are not being achieved.

The **desired effect** for a person experiencing mental illness is to return to a state of mental health. Long term drug therapy and institutionalization is not a definition of mental health. Assuming one or more psychotic episodes indicates incurable psychosis is an unacceptable professional attitude. All components of the process which contribute to chronic mental illness must be challenged. Our search must be for procedures that create and maintain "chronic mental health".

Fear - Our First Obstacle

Fear is the first obstacle to overcome. As part of the human condition we all carry around a number of fundamental fears (e.g. fear of: pain, death, loneliness, insanity). Mental health professionals possess these same fundamental fears. Because of their training, these fears may be even closer to the surface.

Our society is terrified of insanity. The job of gate keeper is assigned to mental health personnel - to identify and isolate the psychotic person as distinctly different from ourselves (i.e. "normal persons"). We drug them into oblivion, isolate them in institutions, label them incurable, suggest the illness is genetic and consider them fundamentally weak in character.

This fear creates an inability as a society, and thus as a profession, to see mental illness as a continuum. We all exist on this continuum. We show up at different places on the continuum at different points in our life. Growing up with exaggerated stress, or subsequently encountering such stress, creates mental illness. If we are fortunate enough to avoid such intense stress we will not experience mental illness. However, every person does have a breaking point. As Drummond states "There is a limit to what people can stand".

After the onset of mental illness a number of fears reside within the mentally ill person which interfere with complete recovery.

1. **Fear of repeated episodes**. Mentally ill persons often embrace inappropriate treatment procedures in an attempt to escape the terror of another psychotic experience.
2. **Fear of stressful environment**. Fear of returning to their stressful environment may create a preference (subconsciously) to accept hospitalization and debilitating drug therapy.
3. **Fear of societal judgement**. Society teaches us that persons with a history of mental illness are weaker and prone to repeated episodes (e.g. "Well, you know Otis has had some mental problems"). The mentally ill person initially believes this. This belief can remove the self-determination necessary to fight the way back to mental health.

Acknowledging these fears is the first step to resolving them. Acknowledged fear can be conquered — fears we deny and suppress remain unresolved. Coping with fear is largely dependent on where we fall

on an introspective - denial continuum. In the past, being less introspective and denying fears more closely fit society's stage of evolution. This would be considered mentally healthy behavior. As we race out into the universe, it is necessary to acknowledge and conquer these fears (individually and collectively) in order to explore new internal and external frontiers.

"The only thing we have to fear is fear itself."[1]

Seductive Aspects of Psychosis - A Second Obstacle

Whether a person recovers from mental illness is largely due to self-determination. A number of seductive aspects of the psychotic experience can severely erode this self-determination.

1. Mental illness serves as a haven from the stress and responsibility inherent in daily living. Our society defines and rewards this option, which as Drummond points out, has not been true in primitive societies.
2. The euphoric and ego-inflating dimensions of some psychotic experiences are as uplifting as the negative experiences are brutal and terrifying. The desire to re-encounter these euphoric experiences can seduce persons into a continuous cycling through psychotic episodes.
3. We all strive to be unique. A psychotic experience is an extraordinarily unique experience. It is easy to get trapped into perseverating on the experiences as a means of defining our uniqueness.
4. A great deal of attention is given to psychotic behavior. Even if this attention is negative attention it is better than being ignored. The poor, the elderly, the adolescents and the females, that Drummond points out populate our mental hospitals, are the persons most often ignored by our society.
5. The psychotic person learns, possibly for the first time in their lives, what it feels like to have power - the power to frighten and intimidate. Drummond emphasizes the preoccupation with power in our society. Paradoxically, those who are driven to insanity due to lack of power find power in their insanity.

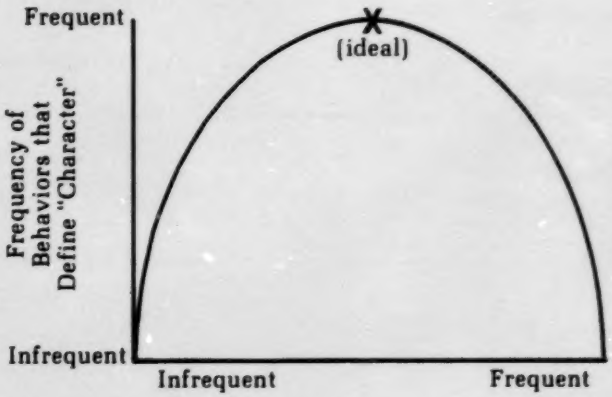
The psychotic world may appear to offer more than the world left behind. This can precipitate a choice (consciously or subconsciously) to remain psychotic. Such a choice creates an obstacle to cure that can defeat the most enlightened treatment/cure program.

Environmental Stress - The Basic Cause

"I do not believe it is possible to pursue the concept of madness until we understand what adversity can do to human beings." (Drummond) The relationship between adversity and character is curvilinear. Too little adversity builds very little character while too much adversity can destroy character.

1. F.D. Roosevelt, Inaugural Address, 1933.

Schematically this relationship looks like the following:



The adversity inherent in environmental stress erodes character and promotes mental illness. "...just prior to a person's having a schizophrenic episode, there was an increased frequency of adverse life events." (Drummond)

Whether we experience periods of mental health or mental illness is due to our environmental circumstances. Did we grow up and/or do we live in poverty or affluence? Do we have loving or hateful interpersonal relationships? Do we have loving or hateful parents? Did we grow up, and/or do we live in a healthy or unhealthy environment (e.g. crime, pollution, nutrition)?

Identifying environmental stress as the underlying causal agent is opposed to assuming mental illness is caused by bio-chemical factors. Yet, it is obvious that a relationship exists between psychosis and bio-chemistry. Psychotic experiences can occur by ingesting hallucinogenic drugs. The aging process can change our bio-chemical balances and create senile psychosis. This verifies the link between bio-chemistry and psychotic behavior. I am convinced persons experiencing psychotic episodes, who are not senile or stoned, develop bio-chemistry imbalances due to frequent and intense destabilizing stress in their environment.

The four stages in creating psychotic behavior would be: (1) destabilizing stress factors, (2) disruption in daily patterns (effect of environmental stress), (3) bio-chemical imbalance (effect of disrupted daily patterns), and (4) psychotic behavior (effect of bio-chemical imbalance). Certain environmental factors establish stabilizing routines and define feelings of self-identity and self-worth (e.g. jobs, close relationships, community). When these factors are initially non-existant or become destabilized for extended periods, a disruption in daily patterns (e.g. eating, sleeping, exercising) results. These disruptions in turn create bio-chemical imbalances which instigate the onset of psychotic behavior.

Notice how closely the following description by Drummond fits this sequence:

> "She stopped writing poetry. Then she stopped dreaming. Then she stopped sleeping. She began speaking incoherently, muttering constantly just beyond what could be heard... she began assaulting strangers in the street, shouting that she was being tortured, that her mind was being controlled by devils, that she was the Messiah and the forces of hell had taken up arms against her."

Focusing on environmental stress as the basic causative agent necessarily defines the focus of prevention and treatment/cure programs.

Prevention

Intervention at any of the first three stages is an attempt to **prevent** the onset of a psychotic episode (stage 4). Creating human environments that avoid destabilizing stress factors (stage 1) is the ideal preventive focus. It is much easier to monitor daily patterns (stage 2) and the bio-chemical levels (stage 3) as indicators of impending abnormal behavior.

To make use of this information requires addressing the four areas of failure mentioned in the introduction: (1) What patterns and levels are relevant?, (2) What constitutes "normal limits" and abnormal deviations"?, (3) How can we monitor changes in these patterns and levels and (4) How can we intervene to make desired changes?

Some possible examples of these patterns and levels, with suggested normal limits and abnormal deviations are:

STAGE 2: Daily Patterns - Sleeping

Normal limits: five to nine hours per day
Abnormal deviations:

1) less than two hours for more than three days
2) more than 12 hours for three or more days

STAGE 3: Bio-chemical Levels - Lithium

Normal levels*: .6 - 1.2 mEg per liter (serum)
Abnormal deviations:

1) too low: 0 - .6 mEg per liter
2) too high: 1.2 - 1.5 mEg per liter
3) toxic: 1.5 mEg per liter

Defining normal limits in daily patterns and bio-chemical levels makes it possible to determine when consistent deviations occur. Daily pattern charts (e.g. sleep charts, eating charts, exercise charts) and bio-chemical level charts should be used to monitor this information.

Consistent deviations serve as a signal to develop an intervention plan. For example; experiencing reduced sleep (2-5 hours) for one or two nights would not necessitate intervention. However, when reduced sleep or no sleep is experienced for three or more nights, an intervention tactic (e.g. short term use of mild medication) might be necessary. If the pattern continues with use of mild medication, professional assistance should be sought to locate stresses in the environment and work to eliminate those stresses.

The exact relationships that exist between environmental stresses, daily patterns, bio-chemical levels and psychotic behavior has not been established. The examples and discussion in the preceding sections speculate on how these factors are related. It is crucial that we remember these are speculations.

Information regarding **daily patterns** and **bio-chemical** levels should be part of standard medical exams. If abnormal patterns or levels are identified, steps should be taken to return the patterns and levels to normal. These measures will hopefully **prevent** the onset of psychotic behavior.

Treatment/Cure

After a psychotic break, the situation is very different than is true in the first three stages. The fear and seductive obstacles mentioned earlier are present. A major self-confidence problem exists once a person has "let go" (in a sense given up). Immediate and intensive intervention is essential. A student who has failed in school for a number of years represents an analogous situation. We are no longer working with an isolated problem but with a complex system of distrust, self-hatred and anger.

To develop a treatment/cure program again requires addressing the four areas of failure covered in the Introduction.

(1) How do we define mentally healthy verses mentally ill behavior?

"Whatever schizophrenia is, it amounts to the breaking of unstated rules of social behavior." (Drummond) These unstated rules must be stated in order to unravel the mysteries of psychotic behavior.

Two components are involved in psychotic behavior. One involves inner behavior that society defines as abnormal (e.g. feelings of being the Messiah). Secondly, this "abnormal" inner behavior is related to unacceptable social behavior (e.g. withdrawal into a trance, talking incoherently, assaulting strangers). These two components must consistently occur together before the person is considered psychotic.

If Messianic feelings are not manifested in verbal or performance behavior, they are undetected and the person is viewed as normal. Withdrawal into a meditative trance, getting drunk and talking incoherently or assaulting a person who has offended us is often considered "normal" behavior. (As long as these behaviors are not associated with bizarre inner behavior.)

*From Beeson, Paul and McDermott, Walsh (Eds.), *Textbook of Medicine, 15th Edition*, W. B. Sanders, Philadelphia, 1979.

Psychotic behavior is a pairing of "abnormal" inner behavior with "abnormal" or anti-social **outer** behavior. The outer behavior can be verbal (e.g. talking incoherently) and/or performance (e.g. assaulting strangers). When a number of inner and outer behaviors are **consistently** paired together, this is symptomatic of psychosis.

Abnormal **performance behavior** is an indication of greater severity than abnormal **thoughts** or abnormal **verbal behavior**.

The number and frequency of behaviors different "psychotic" persons exhibit varies a great deal. There is no standard set of behaviors possessed by all persons labeled psychotic. This makes the label of limited therapeutic use. Instead, specific behaviors that interfere with accepted social interaction need to be identified and changed.

2. How can "normal limits" be defined thus distinguishing "normal" from "abnormal" behavior?

Normal limits involve looking at two factors. (1) How many **different** "normal" versus "abnormal" behaviors are present and (2) How **frequently** (i.e. counts over time) do these behaviors occur in "normal" populations? (e.g. once an hour, once a day, once a year, once every ten years).

The "normal frequency" of many behaviors considered abnormal may be "zero" while occuring as frequently as "once a minute" during a psychotic episode. A "normal frequency average" can be determined by sampling populations of "normal" persons, defining abnormal as one or more standard deviations from normal. By defining "normal frequency of occurance" and "abnormal frequency of occurance", **standards** are created against which to quantitatively define mental health and mental illness.

During the days or weeks of a psychotic episode there can be periods of coherence and normalcy. The ratio between the normal and psychotic periods can be defined by the frequency of certain behaviors, thus serving as a severity index of each episode.

3. How do we measure change (improvement or decline) in mental health?

The improvement or decline in the frequency of inner and outer behavior is the indication of mental health status. For example, consider the normal limits of "thoughts of suicide" as more frequently than three times a year. Change from "one suicide thought per day" to "one suicide thought per year" indicates improvement in mental health.

Monitoring the frequency of inner and outer behavior is done with some type of counting device (e.g. a golf wristcounter, a bracelet abacus bead counter, a countoon[2], a pad and pencil for tally marks) during a standard time period (e.g. a minute, an hour, a day, a month, a year). Only the person behaving can count inner behavior. However, a remarkable analysis conducted by Skolove (1972) indicates that: (1) laws applicable to outer human behavior are also true of inner behavior, (2) inner behavior frequencies are valid measures and (3) inner behaviors can be reliably recorded by the behaver. Outer behavior can be counted by the behaving person or an outside observer.

Graphic records can be used to represent these inner and outer behavior frequencies. These records will then provide a visual picture of the improvement or decline in mental health.

Counting for a day each month, a few inner and outer behaviors symtomatic of mental illness, could serve as an early warning system (similar to a monthly breast self-examination). Behaviors significantly outside normal limits indicate a need to consult a mental health professional.

4. What treatment/cure procedures are available to combat mental illness?

Even if no effective treatment/cure procedures exist, by delineating: normal versus abnormal behaviors (question 1), normal limits and abnormal deviations (question 2) and how to monitor change in the frequencies of these behaviors (question 3), different procedures can be tried and their effects precisely determined.

At the onset of a psychotic episode **short-term** (i.e. one week to two month) drug therapy and hospitalization may be required. As Drummond points out, emotions are so intense that immediate and drastic measures are often necessary.

Medication must be reduced as quickly as possible, and a therapy program developed in a simulated natural environment (e.g. "home-style clinic" versus hospital) or when possible the person's natural home/community environment. The program needs to involve **love**, laughter and trust and provide positive reinforcement for inner and outer behaviors which demonstrate: (1) releasing of the experience, (2) self-determination and self-reliance in decision making, (3) belief in the ability to be quickly cured, and (4) overcoming the fears and seductive aspects of the experience.

Other than the short-term emergency procedures (e.g. drugs and hospitalization) and the self-confidence therapy program, the rest of the therapy program involves identifying and working to eliminate environmental stresses thereby **naturally** re-establishing the daily patterns and bio-chemical levels.

Space did not permit an exhaustive coverage of the four questions. The discussion and examples are intended to provide a conceptual beginning to the development of effective treatment/cure programs.

Positive Potential of Psychotic Experiences

I have discussed the psychotic experience with a negative connotation - an experience to recover from

2. Countoons are cartoons of "a behavior to be counted" with a place to mark how often the behavior occured during a standard time period.

and to avoid re-encountering. There is positive potential in the psychotic experience. However, these positive aspects must be approached with the utmost caution and respect.

In his brilliant five book serial, Carlos Castaneda depicts moving back and forth at-will between states of "ordinary" and non-ordinary" reality. This mental shift is the shift between non-psychotic (i.e. ordinary, reality, "sanity", "mental health") and psychotic (i.e. non-ordinary reality, "insanity", "mental illness") states. These are **different** states of reality, different in their significance and potential. The non-ordinary state is more novel to Western thinkers, and therefore uniquely savage and beautiful. (See *Savage and Beautiful Country* by Alan McGlashan)

Carl Sagan suggests, in his book *The Dragons of Eden: Speculations on the Evolution of Human Intelligence*, the next great leap in the evolution of human intelligence will take place within the two hemispheres of the cerebral cortex. This will involve a better understanding of the left hemisphere (the language hemisphere) and the right hemisphere (the visual imagery hemisphere), and how the two hemispheres interact.

"Ordinary reality" is centered in our language dominated left hemisphere. "Non-ordinary reality" is centered in our visually dominated right-hemisphere. Developing an ease of interaction between the two hemispheres involves a synthesis between Western thought (scientific, mathematical, verbally focused) and Eastern thought (imagery, psychic, Buddhist Prajna). This synthesis can make a richer world for us individually and as a human culture.

Drummond makes several references to the postive aspects of the psychotic experience:

> "Ultimately, there is no difference between the man who thinks he is Napoleon and Napoleon himself."
>
> "The psychotic thus lingers on the threshold of Buddhist wisdom, but in our culture's name repudiates it."

Drummond further comments:

> "And yet there seems to be a difference between the psychotic and the nonpsychotic. The Buddhist who has experienced the wisdom of Prajna and sees the essential unity of things will soon have a new wisdom, called Karuna, which permits distinctions once again to be drawn without losing sight of their illusionary quality."

Persons in our society are not prepared to cope with psychotic experiences. The experiences described by Castaneda take place over a fifteen year apprenticeship (i.e. fifteen years of practice). The devout Buddhist goes through an extended apprenticeship before achieving Prajna and then Karuna. This difference in preparation creates the difference between the psychotic of our society and the enlightened Buddhist.

A similar extended apprenticeship is necessary to learn to move between the two states of reality. Achieving proficiency with "reality shifting" requires the same type of concentrated practice necessary for mastering any complex skill.

Many individuals in our society have had non-ordinary experiences through the periodic or frequent use of hallucinogenic drugs. Persons who have experienced drug induced psychosis or environmentally induced psychosis, and returned to ordinary reality, have learned a number of positive things.

1. They have confronted some terrifying experiences and survived. Anything less terrifying, they can handle.
2. They have expanded their perception of reality. This has increased their knowledge and sensitivities to their internal and external world.
3. They have learned that all people have limits. In a most intense way they have learned their personal limits.
4. They have learned how to "let go". This can be very positive if we in turn learn how to easily return to ordinary reality.

The relationship between ordinary and non-ordinary reality is relative. One state of consciousness defines the other. To live totally in one world prevents understanding the positive and negative aspects of each world - no alternate frame of reference exists.

There are decided risks involved in "reality shifting". The novelty of the non-ordinary world is very seductive. We can stay too long and loose the ties that bind us to ordinary reality, thus slipping into chronic psychosis.

Historically, humankind has risked physical injury and death to explore and conquer new frontiers. Over the last 4 million years, the human species has come a long way in gaining control over the external world. We are at a stage in evolutionary history to risk psychic injury or death in order to explore, for the first time on a large scale, our internal world. The risks of such an internal exploration are balanced against the new insights to be gained.

Until society learns to proficiently teach "reality shifting" as a willful and creative process, the appropriate treatment/cure focus is to return persons to ordinary reality. But let us not neglect to explore the use of "non-ordinary reality", to expand our knowledge and enrich our lives, as individuals and as a species.

Summary

There are limits to how much stress people can stand. If enough environmental stabilizers are disrupted, destroyed or have never been present, our bodies react by developing physical and/or mental illness. Interestingly enough, the link between environmental (psychological) stress and physiological functioning appears present in both "mental" and "physical" illness. Those stresses (environment), which I propose disrupt **bio-chemical**

levels (physiology), are the same stresses (environment) that can disrupt gastric secretions (physiology-ulcers), lower resistance to viral infections (physiology - colds, flu) or possibly even alter the growth of human cells (physiology - cancer).

Finally, remember the relative nature of the "normal" (ordinary reality) and "psychotic" (non-ordinary reality) worlds. The ability to easily move between these two worlds can be a new frontier for human evolution, with real risks but as yet unimagined rewards.

The information shared in this response is based on fifteen years of observing and analyzing emotionally disturbed behavior and from my own experience with mental illness.

The comments, and the specific examples, presented are not exhaustive. I have set forth what I believe to be the appropriate conceptual framework for developing humane and effective prevention, diagnostic and treatment/cure programs.

My hope is this response will become one voice among many. When these voices build to a thunderous roar, then into thunderous action, we will be on the verge of eliminating "mental illness".

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A Reply to Replies

Editor's note:

These responses were shared with Dr. Drummond who wrote with the following reaction:

Many thanks for the responses. They were thoughtful and sensitive pieces, and I'm delighted that my articles helped stimulate them. There is, however, (I'm never satisfied) a missed point.

It is not that psychiatrists and other mental health professionals are "bad" people. Guilt is not a functional state of mind. The issue is that when the influences of poverty, powerlessness and social class on human behavior are ignored, the worth of "mental health" is inevitably irrelevant at best, and destructive at worst. We need to think about social and economic matters as central to our work. This does not mean becoming Marxist revolutionaries (though it might). It means never losing sight of them.

When we develop powerful technologies of behavior control without understanding what role we are playing in society, it is like speeding up when we are lost.

I just read *Small Futures* by Richard H. de Leon (Harcourt, Brace, Jovanovich, 1979) for the Carnegie Council on Children. That's the kind of work that needs to be done.

January 1981

Iowa Perspective Reader Evaluation Form

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Return to Carl R. Smith, Consultant, ED/CD, Iowa Department of Public Instruction, Grimes State Office Building, Des Moines, Iowa 50319.

Thanks to Mary Margaret Kerr from whom we have borrowed much regarding publication evaluation forms.